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THE BRITISH JOURNAL OF DERMATOLOGY

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AUGUST, 1908.

A CASE OF ERYTHEMA SCARLATINIFORME.

By F. GARDINER, M.D., B.Sc., F.R.C.S.E.
Assistant Physician to the Skin-Department Edinburgh Royal Infirmary.

The comparatively rare occurrence of this disease is sufficient excuse for the publication of notes of this case, which, in addition, has some special points of interest.

Mrs. R—, aged 48 years, was first seen on October 10th last, and gave me the following history: Ten years previously she had suffered from a slight eruption on the chest, very like the present rash, but it yielded promptly to treatment. The first sign of this illness was a rash on the front of the chest, which was accompanied with itching and burning of a mild type.

The condition when I saw it was distinctly scarlatiniform in its character and of a dull red hue. Careful inquiries were made to ascertain if there were any cause. No plants were found in the house of an irritant type, no soaps other than the common bar were in use, and no remedies had been applied to the skin; lastly, no new underclothing had been put on recently. No drugs were used before this outbreak, except occasional aperients. The only likely ætiological factor was intestinal toxæmia, and to account for this there was no history of recent faulty feeding, but only that of constipation and old-standing indigestion. The tongue was thickly coated with a white fur, and the temperature was normal.

She was ordered a lotion of boric acid and calamine and given a purge of calomel. Next day the rash had spread over the chest to the neck and face, and during the six days following it gradually advanced till the whole body was involved. There was very great tension on the face where the eyelids were markedly swollen, a similar condition appearing on the lower extremities.

Pari passu the burning sensation and itch became very severe, and at the end of ten days the patient was acutely ill and exhausted from loss of sleep. The temperature never rose above 99° F., but the pulse became very rapid.

After the first day she was ordered 5 minims of vinum antimon. every four hours, but this had to be stopped in a day or two, as the patient felt so faint, and in its place 10 minims of tinct. strophanthus was prescribed.

Within a fortnight the skin of the chest commenced to peel, and this exfoliation, which took place in large pieces, extended gradually to the other parts of the body. Some of the pieces were as large as a sheet of ordinary writing-paper. The rather unusual element of complete generalised alopecia and shedding of all the nails was introduced, a state of matters which I have never seen previously recorded, although it might almost have been anticipated in a severe case such as this.

Four months later the patient was quite well, and the hair had all grown in again.

While aware that the subject is a vexed one and that the differentiation of the cases is not easy, I feel that the following divisions can be made with some surety, and, indeed, this has already been done by others.

(1) Pityriasis rubra pilaris (Devergie). (2) Exfoliative dermatitis following on the use of some external irritant such as iodoform or mercurial inunction. (3) Exfoliative dermatitis as a sequel to Eczema, Psoriasis, Lichen, etc.; this may be combined with the preceding. (4) Toxæmias.

From the history given this case naturally falls under the last head. Continuing this line of thought the eruption may be regarded as Nature's attempt to eliminate the poison. If this is so, then is it some poison which is more powerful in its effect on the skin than others, or is it that the skin is more susceptible in some individuals than in others? The last seems to me the more likely explanation.

This patient had slight Seborrhœa capitis, but many have this and do not suffer from the condition under discussion.

In some diseases there are indications of poisoning such as indicanuria and eosinophilia, but none were found here.

Examination of the blood and urine in Dermatitis herpetiformis has shown that these phenomena often precede a fresh outbreak, and these may have been present in this patient before the eruption appeared.

One may therefore regard the skin condition as Nature's attempt, more or less successful, to eliminate the poison, and, as it is eliminated, there are not the indications in the blood and urine. Further, the poison in its passage is so strongly irritant that it produces the dermatitis.

The rational treatment of the disease is therefore by intestinal antiseptics, and among these carbolic acid is frequently used. Stelwagon gives this remedy in very large doses, watching closely its effect on the kidneys. He recommends twenty to thirty grains daily in glycerine and water, and considers that the usual half to one grain are useless.

In any future case I should be inclined to try this or lactic acid ferment. There is always one reservation, that however valuable these remedies may be in chronic intestinal toxæmias, one need not be surprised at a partial failure here where the mischief is already done. The trial is justifiable in the hope of mitigating the symptoms.

The following other case, though milder, might be also classed as a scarlatiniform erythema.

R. D—, male, aged 23 years, brewer's labourer, came up to the out-patient department of Edinburgh Royal Infirmary on May 18th, suffering from a diffuse rash involving the whole body except the face. The rash was similar to the former case and was accompanied with slight itch.

The history revealed the facts that seven years ago he had suffered from a similar attack, and that up to a month ago he had been taking capsules for gonorrhœa for a period of six weeks or so. Absolutely no other suggestive points could be ascertained—the digestion was normal and the tongue was fairly clean. The suggestion of its being a drug rash at once occurred to one, but a month is too long even for a latent effect.

A boro-calamine lotion was ordered and two days later the condition had subsided.

Is this, again, a toxæmia, and are these well recognised recurring cases always toxæmic ?

GRANULOMA ANNULARE.*

By E. GRAHAM LITTLE, M.D., F.R.C.P.,
Physician to the Skin Department, St. Mary's Hospital.

(*Continued from page* 229.)

XXVI. Audry's case, *Annales de Derm.*, 1904, p. 9.

Female, aged 50 years, who for eight months had had lesions "like those described by Colcott Fox and Dubreuilh." On both hands, especially on the right, on the lateral border of the middle and ring fingers, there were rings formed by thin edge of violaceous-pink colour, very firm consistence, slightly scaly and shiny; these ringed patches seemed formed by the juxtaposition of hard pink nodules. The lesion commenced with a nodule which healed in the centre and spread peripherally. The skin enclosed was almost absolutely normal. There was no pain or itching. Histological examination showed a condition of affairs "like Dubreuilh's case."

XXVII. Model of case of Quinquaud's (dated 1891) in the St. Louis Hospital Museum.

Identified from model by Crocker as clinically like his cases of Erythema elevatum diutinum. Dr. Wickham, the courteous administrator of the Museum, was unable to furnish any further details than those contained in the catalogue, viz.:

"No. 1599. Fibromes multiples nodulaires des extrémités. Diagnostic histologique: Fibrome fasciculé, Mains."

It is interesting in this connection to call attention to Dr. Hyde's addendum to Dr. Montgomery's case (p. 252). Was the case, clinically regarded by Hyde and Montgomery as Granuloma annulare, histologically as keloid, of the same type as this St. Louis model? (*vide* below).

XXVIII. Dr. T. D. Savill's case, *Brit. Journ. Derm.*, 1905, p. 23.

Male, aged 44 years, with a persistent ringed eruption situated upon the neck, chest, and upper limbs. The condition had lasted for eight months. From the scanty notes of the case, which Dr. Savill has been kind enough to lend to me, it would appear that the diagnosis at first suggested was tinea, then syphilis, and

* Paper read at the Dermatological Section of the Royal Society of Medicine on June 18th, 1908.

on this latest hypothesis mercury and iodides had been given. He was under this treatment for five months and then appears to have been lost sight of. He was shown at the Dermatological Society of Great Britain and Ireland, and the diagnosis of "Lichen annularis" suggested.

Microscopically the section (kindly lent by Dr. Savill) showed (Fig. 8) much localised thickening of the stratum corneum, an increase in the thickness of the rete with a very much broader granular zone (five or six cells thick) than usual, and with a copious localised infiltration of cells in the papillary zone of the

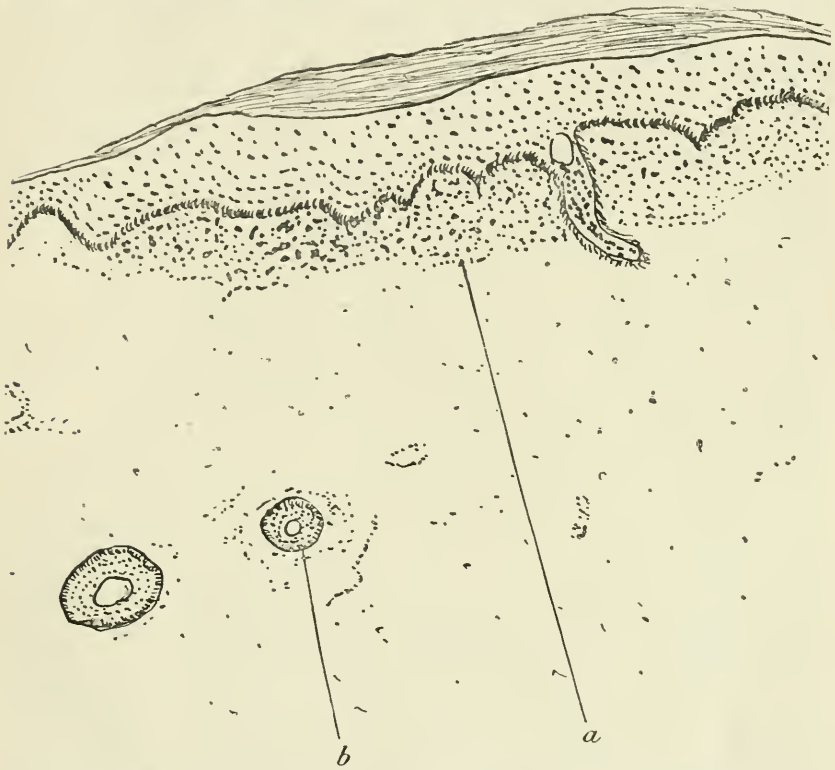

FIG. 8 (drawn with camera lucida).—Savill's case, (Leitz objective 3; ocular 2.) *a*. Dense cell-infiltration of papillary body. *b*. Hair shaft in cross section. Stained with polychrome methylene blue. (*Lent by Dr. Savill.*)

corium directly under the epidermis, and restricted to the superficial layer entirely. This distribution of the infiltration is unlike that seen in any other of the sections I have examined, and I cannot think that the diagnosis of "Lichen annularis" was correct in the light of the histological appearances, which are certainly more like those of Lichen planus.

XXIX. Case shown by Sir Cooper Perry and Mr. Sichel, *Brit. Journ. Derm.*, 1905, p. 61. (Communicated by Mr. Sichel, 1908.)

S. B—, a boy, aged 8 years, presented himself at Guy's Hospital on January

3rd, 1905, suffering from a nodular rash affecting sparsely the extensor surfaces of both hands and feet. The tendency to the formation of circular patches—about the size of threepenny-bits—was well marked, especially on the hands, where the centres surrounded by the nodules were clear but rough. The spots on the hands and feet were said to have begun about two weeks previously.

There was no marked scaliness.

Previous history.—Measles four years ago, and "rheumatism" twice before that, the last attack followed by "inflammation of the kidneys"; his mother

FIG. 9 (drawn with camera lucida).—Perry's case. (Leitz objective 3; ocular 2.) *a*. Dilated sweat-coils with infiltration. *b*. Perivascular infiltration. *c*. Hair-shaft. Section stained with rubin-orange hæmatoxylin. (*Lent by Dr. Whitfield.*)

also stated that he had had a similar rash to the present in the previous summer which went away.

Family history.—Father and mother alive and healthy; one brother and one sister, both alive and healthy.

Patient himself is pale but well nourished. No cardiac bruit, but heart sounds not quite so clear as they should be. When shown he had an intercurrent herpes zoster (abdomen).

January 5th, 1905.—A fresh patch noticed in right lumbar region, also a small, ring-shaped, bruise-like stain in left lumbar region.

January 6th.—Urine acid, sp. gr. 1024; no albumen or sugar.

January 10th.—Slight attack of tonsillitis; urine faintly alkaline, sp. gr. 1016. No albumen or sugar, phosphates came down on boiling.

January 17th.—Rash of herpes on abdomen almost entirely cleared up. That on hands and feet much faded, but otherwise not much changed; a few nodules like "rheumatic nodules" on dorsum of right foot.

FIG 10.—DR LESLIE ROBERTS' CASE. (From water-colour drawing lent by Dr. Leslie Roberts.)

TO ILLUSTRATE DR. GRAHAM LITTLE'S PAPER ON GRANULOMA ANNULARE.

January 18th.—Urine clear, acid, no albumen, no sugar, no excess of phosphates.

February 21st.—Rings all bigger and often not quite complete; the nodules keep separate and do not run into each other. There have also appeared numerous nodules in periosteum (?) of left temporal region, the skin over which is unaffected, not painful or tender.

March 8th.—Two nodules back of left ear and one on back of right ear.

March 15th.—Painted with collodion salicylate.

March 23rd.—Some fresh spots on right foot.

The case was continued to be treated once or twice weekly with collodion salicylate (ʒj–ʒj), and the spots gradually faded. The subcutaneous nodules became smaller without any application in temporal region and ears.

When he was again shown on March 8th Galloway recognised the case as one of Lichen annularis. G. S.

Histology of Perry and Sichel's case. Dr. Arthur Whitfield very kindly gave me a section from this case, from which the following examination was made (Fig. 9):

The epidermis was normal; the granular layer was about 3–4 cells thick; the rete was not thickened. In the deeper part of the corium a nodule of cell proliferation was seen with a low power, which with higher magnification was seen to be centred round dilated sweat-coils. This cell proliferation extended down to the cut margin of the section at the junction of the subcutaneous tissue, and strands of cells were seen ascending from this tumour-formation vertically upwards, round enlarged sweat-ducts, to the middle of the corium. The papillary body was free from infiltration.

The cells seemed to be composed chiefly of connective-tissue corpuscles, with elongated nuclei. Some large mononuclears also formed part of the cell mass.

No data as to elastin were furnished by the section. The collagen was dissociated by the cell-masses, which lay between the bundles in nodular foci, but appeared elsewhere normal.

XXX. Dr. Leslie Roberts' case (communicated). Ringed eruption on the foot, 1904. (Fig. 10, from watercolour drawing lent by Dr. Leslie Roberts.)

The patient was a girl, aged 9 years, and the disease had been first noticed a year previously. There were no subjective sensations and the original patch felt "like a little hard lump under the skin." The disease spread slowly.

The eruption occupied an area of three inches on the outer side of the left foot, reaching a point slightly above the malleolus. When the patient was lying down the colour of the patches was light red, changing to bluish-red when the patient stood erect. When the leg was elevated and the blood pressed out of the foot the rings assumed a dull white aspect. The patches formed rings, the margins slightly elevated, of dull ivory colour, presenting a waxy, glistening surface. The hyperæmia varied also with the temperature; on cold days it was more pronounced, becoming less visible in warm weather. The progress of the disease was very

slow, persisting for many months, and spreading centrifugally. There was no inflammatory reaction. Under treatment the rings disappeared, leaving no scar.

In the section lent for examination by Dr. Leslie Roberts little more than the epidermis is included in the excision. No changes were apparent in that. Dr. Leslie Roberts proposes the name "Acanthoma annulare" in substitution for Granuloma annulare. In the absence of acanthosis this name seems undesirable.

XXXI. Case communicated by Dr. F. H. Montgomery in a letter dated February 21st, 1908. (Case referred to by Dr. Galloway, *Brit. Journ. Derm.*, 1902, p. 218. Fig. 11, from photograph by Dr. Montgomery, lent by Dr. Galloway.)

"The case of ringed eruption concerning which you ask occurred in the son of one of my colleagues in the graduate school with which I was connected some years ago. The boy was brought to me in September, 1899. He was then a rather delicate boy of sixteen. The cutaneous trouble began with what he called 'a small smooth wart' on the radial side of the second joint of the left index finger, in the summer of 1897. It had gradually spread centrifugally. At the time of my examination it extended in irregularly circinate lines about half an inch on to the radial surface of the two adjoining phalanges, and slightly on to the dorsal and palmar surfaces. The borders were elevated two or three millimetres, from two to six millimetres in width, and were more or less distinctly subdivided into individual nodules. The border in colour and density suggested somewhat a keloid, being hard and smooth and presenting no evidence of inflammation or of epithelial growth. The central portion over which the growth had passed seemed to be practically normal; there was no evidence of scar formation.

"I saw the boy again two and a half years later. At this time his father said the lesions had increased until they reached the distal phalanx of the finger, and then, without much treatment aside from irregular applications of a 50 per cent. solution of ichthyol which I recommended, the lesions gradually disappeared until at the time I saw him there were left two slightly umbilicated nodules about the diameter of a small pea. These ultimately disappeared completely."

To this report Dr. Nevins Hyde adds:

"It is proper to say, in order to show there can be errors made by the best meaning of physicians, that about six or eight months ago a patient came to us with a lesion on the left leg which was so precisely similar to those of the Galloway-Montgomery cases that I at once called Dr. Montgomery in to see her. In this case the patient was a woman, and he suggested to me without very much hesitation that it was another instance of Granuloma annulare. There seemed to me, however, to be some distinction here, and this suggestion was based on the special hardness of the underlying tissue. As the ringed eruption did not disappear under what we thought to be appropriate treatment, we excised it and examined it with special care, and found after staining a section of the lesion

Fig. 11.—Case of Dr Hyde and Dr. Montgomery

(From photograph by Dr. Montgomery, lent by Dr. Galloway.)

To Illustrate Dr. Graham Little's Paper on Granuloma annulare.

simply a circinate keloid! I give you this information as it may help you in your *critique* in other supposed instances of the disorder. Externally, however, this patch looked precisely like the others we have seen (*vide* Fig. 16 below).

"It might interest you further to know that neither Dr. Montgomery nor myself has seen any such conditions save in the one case which we photographed and which is referred to above."

XXXII. Professor Jadassohn's cases (communicated by Professor Jadassohn).

Case 1.—Madame X—, aged 59 years. The eruption had commenced two or three years previously in the inguinal region of both sides. Later, it appeared about the axillæ, and on the elbows and knees, on the left side prior to its appearance on the right. There were no subjective symptoms in connection with the eruption, and the patient had no family history of importance, and was herself a stout healthy woman, possibly with "gouty" tendency, and of somewhat nervous temperament, suffering from insomnia.

Distribution of the eruption.—This was symmetric, but everywhere more pronounced on the left than on the right side. Near the axillæ there were very large patches extending on to the surface of the chest and arms. The central part was smooth and perhaps atrophic to a slight degree; the hairs had not fallen out, but the follicles in the centre were somewhat dilated, without, however, being "cornified." In these parts there were some nodules the size of a pin's head, white, firm, and smooth, resembling follicular cicatrices. The edges of the patches were thin (about 1 mm. wide), irregular, very little raised, of a pale, slightly bluish tint, and very little infiltrated. Beyond the limits of the patches there were some macules, very slightly infiltrated and raised, and pale bluish in colour. On the right wall of the chest there were some isolated circinate groups composed of small nodules, sometimes perhaps follicular, and of a pale bluish colour, occasionally even red. The nodules in the middle of these groups were generally paler and less raised, with a more pronounced edge and more circumscribed.

On the left elbow, above the olecranon, there was a patch the size of a shilling, which was more raised, more infiltrated, and redder. The infiltration was general, but the centre was somewhat depressed. A little lower, over the ulna, there was a row of pale pink, small nodules. Over the wrist there was another group, about the size of a sixpence, of nodules, very small and pale. On the left elbow, and on the inner sides of both knees, there were some flat nodules, ungrouped and isolated, of a pale pink. (The patient stated that the large patches had all commenced in this way.)

In the inguinal regions there were some large patches (from which the biopsy was made) exactly like those near the axilla. In no part was there any scaling, scratching, or follicular keratosis. The face, neck, nape, and the rest of the body remained wholly free.

Liq. arsenicalis in 3–10 minim doses was prescribed, and a mercurial plaster and ointment. This appeared to benefit the condition, the effect being apparently due more to the arsenic than to the local remedies, since the eruption improved in positions where no local treatment was used. The condition had recurred from time to time, and was now again troublesome.

Professor Jadassohn was kind enough to send me a section from this case (Fig. 12). There were less conspicuous changes in the skin than in some of the other cases examined, but on the whole I think we have to do with the same class of phenomena.

There are a few collections of cells, encapsuled by connective tissue and lying chiefly in the middle zones of the corium. These cells consist, for the most

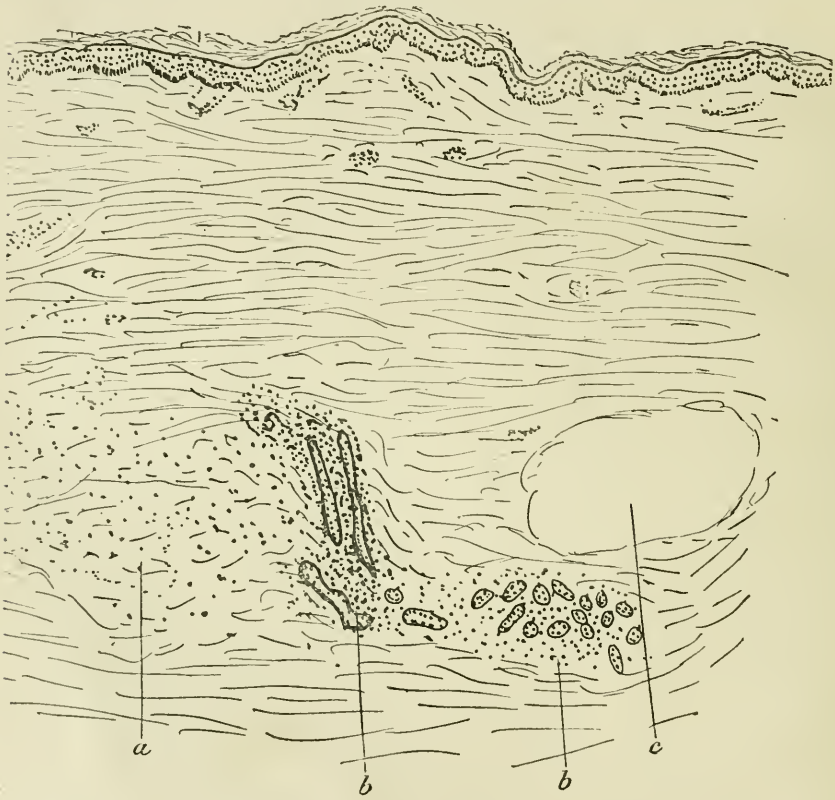

Fig. 12 (drawn with camera lucida).—Professor Jadassohn's case (Madame X—). *a*. Collagen and elastin broken up with diffuse cell-infiltration. *b*. Sweat-coils and ducts with infiltration. *c*. Large blood-vessel cut obliquely. (*Section lent by Professor Jadassohn.*)

part, of vividly stained mononuclears, with many connective-tissue corpuscles and few epithelioid cells; mast cells are not numerous.

The sweat-ducts and coils are in parts of the section surrounded by a fairly dense cell infiltration.

There are also localised areas where the connective tissue and elastic fibres are broken up and interspersed with cells.

The epidermis appears exceptionally thin, but the section was taken, I under-

stand, from the inguinal region, which explains this appearance. The granular layer is "one cell thick."

There is only a small part of the fat zone included in this section, and in a portion of this there appears to be a slight inflammatory infiltration.

XXXIII. Case 2.—Girl, aged 4 years. Disease dates from one year, commencing on the left hand with a patch which gradually enlarged. Within the last three months other patches have appeared on the right hand, on the right foot, and on the thighs. Some patches have disappeared spontaneously. The child complains of itching, not confined to the patches, but, to a slight degree, everywhere, especially about the genitals (the child has worms); she has never scratched the patches; she is a lively child, a little nervous, but of good general health. She had diphtheria some time before the eruption. There is no family disease and no gout.

The child is well nourished, with delicate skin, and blonde hair; the face, trunk, and mucous surfaces are normal. On the right hand, above the metacarpals of the thumb and index there is a patch nearly the size of a five-franc piece, roughly circular, but somewhat irregular, and with the circle broken towards the arm, the centre smooth, of a normal colour, without pronounced atrophy. The edge is nearly continuous, of somewhat serpiginous outline, about a quarter to one mm. wide, of a pale pink colour, without scales, fairly hard, but with a superficial induration, and not sensitive; on pressure with a glass this becomes of a pronounced white colour. On the left hand, in the fold between the index and the third finger there is a circle which crosses the fold in such a way that the circle is continuous only when the fingers are juxtaposed. There is a second circle on the back of the left hand; both these patches are composed of small nodules which form the edge. With this exception they are exactly like those on the right hand. An exactly similar patch, but somewhat larger, is present on the outer edge of the right foot. On the thighs there are some red, smooth stains, sharply circumscribed, not raised or infiltrated.

Fowler's solution and a salicylic acid ointment were prescribed. Four weeks later the patches had grown somewhat larger and a new area had appeared of the size of a sixpence, without central depression, and pale pink, on the third finger of the left hand. No biopsy was obtainable.

Dr. H. G. Adamson's cases:

XXXIV. Case 1 (communicated).—The patient (W. A—) was a boy, aged 3½ years, who seemed to be in good health, except that he was restless at night, which the mother attributed to thread-worms. The eruption—which was not painful, tender, nor itching—had been noticed for six months, the lesions gradually increasing in size and numbers. Over the buttocks and the backs of the thighs there were about fifteen lesions; some in the form of flat, disc-like nodules of the size of a split-pea and somewhat larger; others were well-marked rings of the size of a threepenny-piece to that of a sixpence, the ring itself being formed by a raised, white, firm, half-an-inch wide ridge, surrrounding a pink centre, on a level with the skin surface, and having a narrow pink areola. In some of the rings the ridge was apparently made up of a string of closely-set nodules. On passing the finger over the lesion the firm, raised, circular ridge

could be felt distinctly, like a ring let into the skin. There was one ring on the front of the right leg below the knee. There had been no history of rheumatic fever, nor any evidence of tuberculosis.

XXXV. Case 2 (communicated).

George C—, aged 2½ years. October 29th, 1907. N. E. Hospital for Children. "Lumps" noticed on elbows and "rings" on buttocks, one month.

At the back of the right elbow there are two circular (quarter of an inch across) disc-like swellings in the skin. They are raised above the surface. When pinched up they feel hard and like a corn in the skin. The skin over them is dusky red. There is one similar patch on the left elbow.

On the buttocks there are several ring-like lesions, one on the right buttock and three on the left. They appear as pale lilac rings, slightly raised, with enclosed central part somewhat darker in tint. On pinching up these rings they are found to be firm discs like the others on the arms, and on passing the finger over the lesion the raised margin and central depression can be easily felt.

The case was lost sight of at this stage.

XXXVI. Case 3, *Brit. Journ. Derm.*, June, 1908. (Fig. 13, from photograph by Dr. Adamson.)

"The patient was a printer, aged 17 years. Five months ago 'small red lumps' appeared upon the backs of the fingers and gradually increased in size. When he first came under observation one month ago there were present on the dorsal surfaces of the fingers of both hands raised, firm, dusky-red, nodulated, disc-like areas of from half-an-inch to one inch in diameter, and elevated about one-eighth to three-sixteenths of an inch. All the fingers of each hand were involved; in some the dorsal aspect of one phalanx, in others of two phalanges, and in the case of the first finger of the left hand the lesion extended over the middle joint. On close inspection, and particularly on palpation of the raised disc-like areas, it was evident that they were made up of closely-set pea-sized nodules; but it was only on careful examination that this feature could be made out, for the individual nodules were close together and their margins were ill-defined. In some of the patches there was a tendency to ring formation, owing to the arrangement of the nodules towards the margin of the patch. The hands were cold and of a dusky hue. There were in addition a few isolated pea-sized dusky-red nodules on the backs of the hands. One of these was excised, and within a fortnight the whole of the lesions had almost disappeared. It was curious that a similarly rapid disappearance of the lesions had occurred in a case of 'ringed eruption' recorded by Dr. Graham Little after a biopsy. The exhibitor regarded the case as belonging to the group of cases variously described as 'ringed eruption' (Colcott Fox), Granuloma annulare (Crocker), Lichen annularis (Galloway).

"A section of one of the lesions from the back of the hand showed some widening of the prickle-cell layer and of the horny layer of the epidermis (possibly due to the fact that the section had been cut obliquely). In the corium the fibrous connective tissue was normal, but in it there were numerous circumscribed collections of mononuclear round cells around the blood-vessels, and a large mass

Fig. 13.—C. D—, aged 17. April 24, 1908. O.P., No. 1006. St. Bart.'s.
"Ringed eruption" Granuloma annulare (?). Erythema elevatum diutinum (?).

To Illustrate Dr. Graham Little's Paper on Granuloma annulare.

of the same type of cells around the sweat glands. There were no young connective-tissue cells, epithelioid cells, plasma cells, nor polynuclear leucocytes. The absence of young connective-tissue cells described in other cases was probably due to the fact that the lesion excised was at a very early stage. The clinical

FIG. 14.—*a a*. Blood-vessels surrounded by masses of mononuclear round cells. *b b*. Collections of similar cells around sweat-glands.

features and the histological findings suggested a toxic rather than a microbic origin." (Fig. 14 from a drawing by Dr. Adamson.)

(*To be continued.*)

ROYAL SOCIETY OF MEDICINE.

DERMATOLOGICAL SECTION.

An ordinary meeting of the Section was held on Thursday, July 16th, 1908, Dr. Colcott Fox in the Chair.

Dr. H. J. Adamson showed a case of *ringworm* with *rose-coloured cultures.* The patient was a man, aged 48 years, a porter in a city warehouse. He was sent to St. Bartholomew's Hospital by Dr. Crawford Lindsay, of Hendon. He had had ringworm for twelve months. It had first appeared as a "ring" on the back of the neck. It had since spread gradually over the neck, the beard region, and on to the arms. When first seen at the hospital on May 8th there were numerous dusky-red and very slightly infiltrated flat nodules on the chin and whisker region, and similar larger flat nodular areas on the back of the neck. The patches on the chin were the seat of curled-up hair stumps. On the left forearm there were two large circinate areas with slightly raised infiltrated margins. The curled-up hair stumps on the chin (which clinically suggested an endothrix ringworm) showed under the microscope the appearances of a microsporon ringworm. The hair was surrounded by a dense sheath of small spores with here and there chains of larger spore elements. Towards the root the interior of the hair was filled with short-jointed mycelial threads running parallel with the shaft. The cuticle of the hair was eroded. The appearances were in fact those of a microsporon, except for the occasional chains of spores in the external sheath. On Sabouraud's medium cultures were grown which were downy, at first white, afterwards becoming pink or *rose-coloured.* They were rayed in folds from the centre. The exhibitor was not familiar with the culture; its downy white appearance suggested, like the microscopical appearance of the hairs, *a microsporon of animal origin;* but the later pink or rose colour was unusual—and Dr. Colcott Fox, who saw the cultures, suggested that they were Sabouraud's *Trichophyton ectothrix à cultures roses,* a form of ringworm which had not yet been met with in this country. The exhibitor proposed to send one of the culture tubes to M. Sabouraud in order to ascertain whether this were so or not. The fructification consisted of mycelial threads with short

lateral branches bearing groups of oval and rounded spores. There were no fusiform elements. Cultures were exhibited. In spite of the close resemblance of the cultures to the published photographs of Sabouraud's Trichophyton ectothrix à cultures roses (Trichophyton rosaceum d'origine aviaire), the exhibitor was inclined to regard them as a hitherto *undescribed form of microsporon* with pink or rose-coloured cultures. The patient had for long had canaries in the house, but the infection was too far back to enable its being traced to these.

Sir Malcolm Morris said that at the present time there was an epidemic of Eczema marginatum in one of the public schools, and that the fungus could be got in a moment. In another public school a year ago the same thing occurred. In the public school epidemics it always spreads from the same spot.

Dr. Colcott Fox said he had cultivated a number of cases of beard ringworm, indeed, all the cases he had seen recently both in private and at Westminster Hospital, and they had all given a violet culture. Clinically the lesions consisted of little scurfy places and "black dots." He seldom saw an inflammatory case in the beard.

Dr. J. L. Bunch showed an *anomalous tuberculide* in a girl, aged 11 years, who was admitted to the North-Eastern Hospital for Children two days previously with erythematous and pustular lesions on both legs extending from the knee to the ankle. On both legs there were also thickened, indurated and infiltrated areas with adjoining scarred portions, most marked on the left leg, where the disease had first commenced two years ago. According to the mother's statement this had first shown itself as a raised red swelling over the left tibia about four inches below the knee, which increased slowly in size, broke down and discharged for some time. This was followed by further indurated swellings on both legs seven months ago, which were not treated, the child attending school all the time, and the legs being allowed to get into a septic condition, which was well marked when admitted to hospital. At the present time there is also a raised, readily-bleeding granulomatous mass at the back of the right leg, elevated about a quarter of an inch above the surrounding skin. A probe passed into this does not apparently reach bare bone. On the right side of the face, below the ear, is a flattened, somewhat raised red patch surrounded by a few scattered papules which have made their appearance during the past two days since a dressing has been applied. Enlarged discrete glands, not attached to the skin,

are present on both sides of the neck. On the left buttock is a raised red indurated swelling, and one or two adjacent nodules considerably smaller in size. No history pointing to congenital syphilis could be obtained, and, as the case was apparently a tuberculide, the Calmette and tuberculin injection tests were applied. On July 18th some ½ per cent. Calmette tuberculin was applied to one eye, and twenty-five hours afterwards a positive reaction was obtained, the caruncle became red and inflamed, lacrimation was increased, and the conjunctiva and circumcorneal area congested. On July 21st patient's opsonic index to tubercle was ·74. $\frac{1}{10000}$ mgrm. tuberculin was injected into the forearm subcutaneously, and on July 23rd her opsonic index to tubercle had risen to 1·08. It is proposed to continue tuberculin injections and give her X-ray treatment in addition.

Dr. Colcott Fox and Dr. Graham Little regarded the condition of the legs in this case as chronic pus infection, and questioned the tuberculous character.

Dr. G. Dawson showed a case of *Parakeratosis variegata*. He had shown the patient, a female, last winter, when Dr. Crocker said he thought it was a case of Parakeratosis variegata. The rash occured two and a half years ago on the ears and face, and now it had extended on to the knees and arms, and there was some on the buttocks. It was intensely irritable, and kept her awake at night. It had not been treated by any drug. He could not find any reason for the peculiar distribution. At first he thought it was Lichen planus, but there had never been any thickening. He did not think the mucous membrane of the mouth had ever been involved.

A section from the case was exhibited.

Dr. Colcott Fox questioned the diagnosis of Parakeratosis variegata, but was not prepared with an alternative one.

Dr. Colcott Fox exhibited a milkman (Robert R—), aged 20 years, who was the subject of an *erythematous eruption*. The man states that the present attack began about Whitsuntide, first as small slightly raised blotches on the hands, then on the feet and body. He has not any joint trouble, pains, or marked constitutional disturbance. There are confluent round patches of erythema, disappearing on pressure, all over the hands and feet. The palms and soles are

diffusely involved, but there are large round macules on the borders, and disseminated over the dorsum of several of the joints, where they are raised, thickened and opalescent, suggesting a certain amount of serous exudation. There are a few patches over the elbow-joints externally, and one or two symmetrical patches on each forearm; also on the sides of the legs. The mouth is free. The man states that the scalp was affected, but it is now free, and as there is an ill-defined roughened patch on the centre of the sternum there may have been some pityriasis. The man also states that he had a similar outbreak last Christmas, and that his scalp was first involved, and then the arms and chest. The eruption disappeared about Easter time. The exhibitor said he had brought the case because, although the type was erythema, the picture on the hands and feet especially was very striking and unusual, and the individual lesions and the eruption as a whole were more prolonged than usual if the man's story was to be depended on. The exhibitor said he also had under observation a very similar case in a woman, who had long suffered from a chronic patch of Lupus erythematosus of the nose, with lesions of the backs of the fingers, and who suddenly had an outburst of large macular erythema (? acute Lupus erythematosus) with marked incidence on the hands .and feet. The outburst was, however, of short duration.

Dr. Wilfred Fox showed a case of *X-ray dermatitis*. The patient, a medical man, showed on his hand an early stage of X-ray burn. The first sign of it appeared in the middle of April, and Sir Malcolm Morris had watched the condition with him since then. It had gradually progressed, and there was steady infiltration. It arose from the frequent screening of patients, and was a "series-burn." It was steadily becoming more painful, especially about the nails There had been no injected venules, but slight pressure produced pain. He asked whether anyone could suggest any means of stopping the pain.

Dr. David Walsh showed, on his own first finger, the site of a typical X-ray wart, which he acquired when using X-rays four or five years ago. He had now ceased to do such work, but while he was working at it he was very careful of his hands. His own was a "series-burn."

Dr. Galloway brought forward the case of a young man, aged 23 years, suffering from an unusual type of *Dermatitis herpetiformis*.

The patient describes himself as never having been in robust health, but physical examination discloses no obvious visceral lesion nor signs of disease, with the exception of the condition to be described.

In December last he had an attack of what is stated to have been influenza, the temperature rising on this occasion to 103° F. His convalescence seems to have been somewhat protracted. During the month of January he had an attack of gonorrhœa, from which he rapidly recovered, and which had completely disappeared by the beginning of April. During this attack he was at one time treated by the administration of sandalwood oil in capsules, and suffered in consequence from an erythematous eruption, which, however, seems to have vanished in the ordinary course. At the end of March he developed a few spots on the right forearm which he says was the commencement of his present disease. These spots are stated to have been red and slightly raised above the surface. He states that some of them showed slight blistering. The eruption rapidly advanced till it attained its present extensive distribution. In the early part of May, the skin-disease rapidly advancing, he was sent to Margate for the benefit of his health, and consulted Dr. John L. Sawers. During his stay in Margate the attack increased in severity, and on account of this Dr. Sawers communicated with Dr. Galloway respecting his condition. The acutest stage of this attack seems to have occurred during his stay in Margate. On returning to his home in Croydon he again came under the care of his usual medical attendant, Dr. Robert C. Brown, who also communicated with Dr. Galloway on account of the peculiar symptoms presented by the case. The patient was then sent to be under Dr. Galloway's care in Charing Cross Hospital.

The following note was made of the condition of his skin shortly after admission: "The eruption consists of dark erythematous patches distributed universally. It is most profuse, however, on the face, upper and lower extremities, and the upper portion of the trunk. The parts least affected are the anterior surfaces of the abdomen and thorax, the lumbar region of the back, which is practically clear, the hands and feet. On more minute examination the erythematous patches are found to be made up of rounded spots of purple-red tint from 25 to 50 millimetres in diameter grouped in irregular corymbose areas. The patches so formed are from two to three centimetres in diameter, but tend to become confluent, forming larger areas of

eruption. The individual small spots show distinct atrophy with a smooth, glossy surface. There may still be seen vesico-pustules, especially at the margins of the areas of disease. Here and there individual isolated spots may be noted. The skin-disease gives indications of having originated throughout as a vesico-pustular eruption.

"On admission the affected areas were thickly encrusted, partly, no doubt, owing to the formation of true epithelial crust, but mostly as the result of the concretion of dressings containing powders. On the face, especially the bearded parts, a slight dermatitis, eczematoid in character, was noticeable. The scalp is affected with the disease, but there is no indication of affection of the mucous membranes, with the exception of a slight amount of the eruption on the glans and preputium penis. A slight marginal blepharitis exists, apparently of secondary origin, and occasional slight conjunctivitis is observed, but it is not clear that vesicles form on the conjunctivæ."

The patient has been examined carefully to ascertain if visceral disease of any sort can be identified, but the results have been negative. The urine, repeatedly examined, is normal; the blood, examined on July 10th, shows the following state:—

Hæmoglobin	90 per cent.
Red blood cells	4,890,000 per c.mm.
Leucocytes	6,000 ,,
Polymorphonuclears	63·6 per cent.
Lymphocytes	6·2 ,,
Large mononuclears	20·8 ,,
Transitional	4·2 ,,
Eosinophiles	5·2 ,,
	100·0

There was a slight rise of temperature on admission to about 100° F., with widespread enlargement of lymphatic glands. These were most noticeable on the neck, where those in the neighbourhood of the sternum mastoid were as large as filberts. They were, however, soft, and gave the impression of glands enlarged from septic absorption, which might easily be accounted for by reason of the crusted character of the eruption on the face and scalp.

The treatment made use of in the hospital was, first, the use of daily bran baths. The surface was then dressed throughout with a

cream consisting of almond oil and lime-water. By this means the crusts were rapidly removed, the temperature falling to normal. The patient now had a bran bath daily, and was dusted from head to foot with a neutral dusting powder of zinc oxide and silicious earth, containing 10 per cent. boric acid. When shown to the Society the deeply congested and atrophic appearance of the eruption could readily be made out. It was apparent that the violence of the attack had ceased; no recent points of eruption could be seen. It was especially to be observed that no lesions of simple erythematous or urticarial character were noticeable nor had they apparently occurred at any time during the disease.

Dr. Galloway drew attention to the unusual type presented by this case, although no doubt it could be grouped as an example of Dermatitis herpetiformis. He drew attention to the fact that there was little or no pain, only a certain amount of general irritation; that none of the concomitant lesions of Dermatitis herpetiformis (*e. g.* urticaria and erythema) had been observed. The spots affected by the disease became universally congested; they gave rise to feeble vesication, the fluid becoming turbid rather than definitely purulent, and when the epidermis separated the rounded spot of purple atrophic skin remained as the relic of the disease. This type of Dermatitis herpetiformis in his experience was very unusual, and reminded him of the earlier descriptions of Hydroa herpetiformis before Duhring's account of the disease became so universally accepted. Dr. Galloway hoped to receive suggestions from members of the Section as to any means of further investigation of this very severe and unusual condition. To his mind it seemed probable that the eruption was due to a cause, probably of internal origin, and in some respects might be regarded as analogous to the rare acute, "exanthematic" outbursts of what had been called Lupus erythematosus.

Dr. Colcott Fox said that he had had the opportunity of seeing this interesting case previously with Dr. Galloway. The picture presented by the patient immediately brought to his mind one of the patients from whom Dr. Tilbury Fox had originally given the description of what he called Hydroa herpetiformis. He considered that the case could well be classified under the heading of Dermatitis herpetiformis, but the type was quite unusual and peculiar. He was glad to observe that the patient was so much improved in his condition since he had seen the case in Charing Cross Hospital with Dr. Galloway.

Dr. PERNET remarked on the important analogies which existed between an eruption such as this, consisting of a severe erythema followed by atrophy of the skin, and the acute types of Lupus erythematosus. He thought that the analogy might prove to be more than one of simple interest, and if followed out critically might give information as to the ætiology of these conditions.

Sir MALCOLM MORRIS remarked that he considered that the fact that the disease before the Society consisted of lesions which were defined from the outset, showing no tendency to peripheral spread, was sufficient to make a clear diagnosis between the disease presented by the patient and cases of exanthematic Lupus erythematosus. As to the causation of the present case he was especially interested to hear that an erythematous eruption had followed the use of sandalwood oil. The disturbance so produced might, he thought, be of some importance in the history of the case.

Dr. WHITFIELD said that at the present time, the violence of the eruption having become spent, suggestions as to immediate treatment were not necessary. He considered, however, that during the development of such cases the coagulation period of the blood should be carefully watched. He thought that it was quite possible that the damaging effects of the disease on the skin might be, at any rate to some extent, controlled by the use of lime salts according to the variations in the coagulability of the blood. Dr. Whitfield did not agree with the suggestion that any clinical analogy existed between this case and any of the types of Lupus erythematosus.

Dr. GALLOWAY thanked the members present for their criticisms and suggestions in this case, and hoped that he might be able to take advantage of them in treatment. He especially desired to acknowledge the interest of Dr. Sawers and Dr. Brown, who had sent the case to him.

Dr. GRAHAM LITTLE showed:

(1) A case of well-marked *rosacea* associated with phlyctenular conjunctivitis and ulceration of the right eye, and to a less degree of the left eye also. The patient was a man, aged 52 years, a carpenter by trade, and he had suffered from rosacea for five years; the exacerbations of this disease were usually accompanied by phlyctenular conjunctivitis. The case had been sent from an ophthalmic surgeon with a view to ascertaining whether dermatologists were as familiar with the association of eye-affection of this type with rosacea as ophthalmic surgeons were.

Dr. WHITFIELD said he had frequently seen the association. The ophthalmic surgeon at King's College Hospital had drawn his attention to such cases, and had found staphylococci as a rule in the lesions of the eye, which usually improved coincidently with treatment for rosacea directed to remedying the dyspeptic symptoms of that disease.

(2) A case of *prurigo of Hebra* in a foreign Jewish girl, aged 6 years. The affection had first been noted at the age of 18 months

and had persisted ever since. The child was covered with the characteristic itchy papules of the disease, the whole body and face being involved. The papules were closely grouped, of the size of a small pea, and very irritable. On the arms and legs there was a secondary, very severe chronic pus infection. All the glands in neck, axilla and groin, were greatly and visibly enlarged. The child was deeply pigmented, probably as a result of the itching, the mother being moderately fair. No other members of the family had the disease. The age at which the patient had become affected—eighteen months—was older than the majority of cases reported by Hebra and Kaposi, but it was certain that Hebra's prurigo sometimes commenced in later childhood. The exhibitor had recorded a case which began at the age of six years, commencing after an attack of scarlet fever, and other even later commencements had been reported.

Dr. Colcott Fox said that he had been struck with the fact that whereas Lichen urticatus, which was sometimes regarded as the forerunner of Hebra's prurigo, commenced in the early months of infancy, true prurigo more commonly in his experience, commenced later—at the age of four or five years. It remained, however, a very rare disease.

(3) A case of *Molluscum contagiosum*, of perfectly typical aspect, in a man, aged about 35 years, with lesions confined to the pubic region of the abdomen and to the penis, two molluscum tumours being found on the prepuce. There were about seven lesions in all, and the typical white waxy material had been extruded from the tumours and demonstrated microscopically. The exhibitor thought the distribution on the penis sufficiently interesting to record. No source of infection had been identified. Molluscum contagiosum was not a common disease in adults, and it was curious that in some parts of the country the disease itself seemed extremely rare; Dr. Arthur Hall, of Sheffield, had told the exhibitor that they had not met with a case in Sheffield for very many years.

Dr. Colcott Fox said he had seen numerous cases of Molluscum contagiosum in the children in the poor law schools provided for ringworm, and the scalp was a very frequent position for the tumour to appear.

(4) A case of *Pityriasis rosea*, with a very extensive and characteristic eruption occupying the chest, abdomen, back, arms and forearms, thighs, and, which was extremely uncommon, the face. The latter part was covered for three fourths of its surface with quite

characteristic small circinate patches. The disease had commenced as an acute efflorescence eight days previously and there was no history of a pioneer patch.

Sir MALCOLM MORRIS drew attention to the unusual season of the year for Pityriasis rosea to develop, but said he had himself seen quite an epidemic of the disease recently. He pointed out the extraordinary similarity of the lesions on the forearms to a secondary syphilide; he had recently seen a case of Pityriasis rosea involving the face, which he had at first regarded as possibly Lupus erythematosus, considering the rarity of Pityriasis rosea in this position.

Dr. WHITFIELD did not think the face was very rarely involved; he had seen more than one such distribution, and had found it on the scalp as well.

Dr. SEQUEIRA showed two cases of *congenital syphilis* with late cutaneous and mucous-membrane lesions of the gummatous or phagedænic type.

CASE 1: *Extensive gummatous ulceration of the nose and lip with gummatous hepatitis.*—Esther B—, aged 11 years, admitted to the London Hospital on June 18th, 1908. The mother, a Russian Jewess, gave the following history: She has enjoyed good health. She has been married nineteen years. She has had ten children, of whom six survive. Her first and second children died within a few weeks of birth. The third child was stillborn. The fourth child, a boy, now aged 17 years, is in good health, and there is no history of any syphilitic manifestation. The fifth child died from measles at the age of 9 months. The sixth, a girl, now aged 14 years, had some skin eruption when she was between eleven and twelve years of age. She shows no signs of syphilis. The seventh child is the patient now shown. The eighth child, a boy now aged 9 years, had "blisters" on his limbs when two or three years old. The ninth child, aged 5 years, had a "sore" on the roof of his mouth when one month old. The youngest child, now aged 3 years, had a rash all over the body and upper and lower extremities when one month old.

The four younger children were examined but no evidence of congental syphilis was discovered.

The father is said to have suffered from "ulcerated legs" a few years after he was married. No direct history of syphilis was obtainable.

Patient's history.—When 6 weeks old she had an eruption between the legs and around the genitals and buttocks. Vaccination

"took very badly." The mother describes the vaccination spots as forming deep "holes" which took three or four weeks to heal. The child had some "inflammation of the eyes" when she was two years old, and after this the abdomen began to swell. Tuberculous peritonitis was diagnosed, and she attended a dispensary for three years, being given ol. morrhuæ and malt. At one time also some inunction, apparently of mercurial ointment was prescribed.

Two years ago (at the age of 9) a small lump appeared at the left inner canthus, evidently a suppurating dacryocyst. The abscess "broke," and has discharged more or less ever since. A little later the opposite lachrymal sac was similarly affected. One year ago nasal discharge began, and the mother describes the inside of the nose as "decaying and coming away." The discharge at this time was offensive and often blood-stained. During this period the nose became steadily flatter. The child at this time attended two hospitals, and was an in-patient at one for seven weeks.

Six weeks prior to admission at the London Hospital the upper lip became swollen and ulcerated. The ulceration rapidly increased and the lip "split" on June 8th.

[Dr. Sequeira acknowledges his indebtedness to his clinical assistant, Dr. W. G. Parkinson, for his care in obtaining so complete a history in very difficult circumstances].

Condition on admission, June 18th, 1908.—The child is very anæmic and her face is terribly disfigured. The nose is flat, level with the cheek, and ulcerated. The upper margin of the ulcer has a serpiginous punched-out margin, suggesting the coalescence of three gummatous ulcers. The lower part of the nose is almost entirely eroded, and presents an ulcerated surface which is continuous with a huge ulcer on the upper lip. This extends the whole width of the nose, and presents one very deep and one smaller fissure, which split the lip up nearly to what would be the anterior nares. The surface is dirty yellowish-brown, and from it and from the interior of the nose a most offensive sanious discharge is continually pouring. Both lachrymal sacs are suppurating, and pus exudes from two sinuses connected with each.

There is no ulceration in the buccal cavity, and the pharynx and palate are free. The upper central incisor (left) is of the Hutchinson type.

There is no interstitial keratitis, and no choroiditis has been made out on ophthalmoscopic examination.

Visceral lesions.—The abdomen is enormously swollen, and huge dilated veins cross from it on to the thorax. The umbilicus is protruded. The liver is irregularly enlarged. Its lower margin extends in an irregular curve downwards from just below the margin of the ribs in the mid-axillary line to the umbilicus. On the left side the hepatic dulness is continued into that of the enlarged spleen. The surface of the liver presents large rounded bosses, which are obvious on inspection and easily made out on palpation. The heart is pushed up, and the apex beat is nearly one costal space higher than normal. The spleen extends down to and a little beyond the umbilicus. Its surface is smooth to palpation. There is universal enlargement of the lymphatic glands, those in the groins, axillæ, and neck being easily visible, and on palpation of extreme hardness. There has been no albuminuria and no diarrhœa. There is advanced genu valgum on the right side.

The child has been kept in bed and given plenty of nourishing food. Mercurial ointment, 1 drachm per diem, has been rubbed in, and iodide of potassium, in 5 gr. doses, has been given internally. The nasal cavity has been irrigated with lotio nigra. The ulcers have been dressed with an ointment of peroxide of zinc (40 gr. to the ounce). Improvement has been extremely rapid, and when shown at the meeting, exactly four weeks after admission, most of the ulceration had healed. A remarkable feature has been the amount of repair, especially in the lip. The child will, of course, be terribly deformed, as a considerable part of the bony nose as well as the cartilage has been destroyed.

Case 2: *Extensive gummatous ulceration round the mouth.*—Thomas H—, aged 15 years, admitted to the London Hospital on June 29th, 1908.

Family history.—The patient is the eldest of five children, the other four being girls. No details are obtainable as to their infancy, but so far as is known they have been in good health. No information is to be had of the health of the parents, the boy being sent from an institution.

Personal history.—There is no information as to the patient's condition in infancy, but he states that he was well until three years ago.

Present illness.—The first manifestation was a "lump" which appeared on the middle of the right cheek three years ago. This "broke" and ulceration extended over the right cheek, as high as the outer canthus of the eye, and inwards to the right side of the nose, involving the ala and part of the tip of the organ. On one occasion the area was scraped. The boy, who is intelligent, states that the ulcerated area healed up while he was taking medicine, and remained well for over a year. Three months ago a fresh outbreak occurred on the upper lip, and the ulceration spread round the left angle. One month ago a swelling appeared on the lower lip and this rapidly broke down into an ulcer.

Condition on admission, June 29th, 1908.—A large area of scar tissue extends all over the right cheek from the lower lid to the mandible, internally reaching the side of the nose, the ala of which and part of the tip have disappeared. There is extensive ectropion of the right lower lid, the result of the contraction of the scar.

On the upper lip there are two foul ulcers covered with yellowish slough and with a yellowish sanious discharge. The ulcer on the right side extends from the angle of the mouth to near the middle of the lip. That on the left side starts half an inch from the middle line and extends along the upper lip, round the left angle in horseshoe form, and is continuous with a large ulcer on the lower lip, which reaches nearly to the right angle. The ulceration is partly of the skin and partly of the mucosa. It is everywhere about one half to three quarters of an inch across. Its edge is steep and irregular. The middle of the upper lip is swollen and everted but not ulcerated. There is constant dribbling on account of the condition of the lower lip, but there is no ulceration of the buccal cavity or of the palate or pharynx. The interior of the nose, so far as it can be seen, is normal.

There is a small opacity on the right cornea, but this looks more like the result of a corneal ulcer than interstitial keratitis. No choroiditis could be made out on ophthalmoscopic examination. There is a characteristic Hutchinson tooth (upper left incisor). There is no evidence of visceral implication. The boy's general condition is good.

The patient was shown eighteen days after admission, and the ulceration had almost entirely healed. The treatment had been identical with that pursued in the other case.

Cases of this type of congenital syphilis are fortunately exceedingly rare, but the exhibitor had another under his care in September, 1907 (described with photographs by H. Emlyn Jones, *British Journal of Children's Diseases*, April, 1908, p. 144).

The importance of early recognition of this condition is obvious. In the first case shown the abdominal visceral disease was diagnosed as tuberculous peritonitis, and when the nasal and cutaneous lesions appeared they were considered to be lupus. A diagnosis of lupus had also been made in the second case. The fulminating character of the disease and the terrible deformity which so rapidly results call for early and energetic treatment.

It is of special interest to record that in both these cases Calmette's ophthalmic tuberculin test was tried, and in each instance there was no reaction. In the event of there being doubt as to the diagnosis between lupus and inherited syphilis this test is of value, as a positive reaction has always been obtained in Lupus vulgaris.

Dr. Walsh showed (1) a case of *primary cutaneous carcinoma* of the chest involving the neighbouring nerve areas. The patient, H. M. M—, aged 54 years, a clerk, was first seen June 25th, 1908, complaining of so-called "shingles," for which malady he had been treated by a medical man. Patient looked thin and anxious; said he weighed 10 stone 12 pounds (not enough for his height), and had lost 3 pounds' weight in the last twelve months. His general health had always been good until eighteen months ago, when he was laid up six weeks with what he described as "a very bad heart." Six months later he noticed a hardness and red discoloration of the left nipple. This grew to the size of a hand, when he consulted a medical man, who said it was shingles. It had grown steadily ever since. There had been no pain except on one occasion, four months ago, when he was suddenly seized in the region of the liver with pain of a week's duration. Water formed in the abdomen, and he was tapped twice. There had been no return of either the pain or the dropsy.

On examination, a sheet of pink and red nodules, for the most part confluent, was seen on the left chest. In the left nipple line it reached from the lower border of the third to the eighth or ninth ribs with a vertical measurement of some seven inches. It extended across the lower part of the sternum, and at the right nipple line formed a

tapering band of discrete nodules about two inches broad. Higher up on the right chest above the nipple were two small, recent patches, the highest at the level of the third rib. The nipples looked normal in shape and size, although the left was closely wedged in by a mass of nodules.

At the back the main sheet of eruption ends, about two inches behind the posterior axillary line. Three inches from the spine at the lower level of the main eruption is a group of discrete nodules, the size of half-a-crown, with a similar group some three inches higher up inside the angle of the scapula. Over the front of the left shoulder-joint is a group of firm sparse nodules about the size of a hemp seed, while at the back over the long head of the triceps and beneath the deltoid muscle is a reddish patch, about two inches across, in which can be felt minute commencing nodules. In front of the middle of the left biceps is an irregularly bordered reddish macule, about the size of a crown, in which a slightly nodular feel can be made out on careful palpation; on the inner side of the middle of the left upper arm is another similar patch, and a third in the back of the triceps.

The nodules vary in size from a millet seed to a pea, and are of various shades of pink and lake colour, with a brownish tint in places. They are firm and movable, not tender on pressure, and have never been painful. About a week after coming under observation some small hæmorrhagic points appeared.

A nodule the size of a split-pea was excised, and a microscopic examination showed an alveolar stroma of connective tissue packed with epithelial cells beneath an unbroken epidermis.

The heart sounds were normal. Superficial veins of abdomen enlarged. Liver dulness about normal; somewhat enlarged area of dulness in splenic region. Patient has not complained of pain in abdomen (except during the single attack above mentioned), neither has there been any marked bowel disturbance.

A mass of hard glands can be felt in each axilla, somewhat larger in the left. Small hard glands can be felt both above and below the collar bones, especially on left side.

There are several points of interest in this case. The new growth, although it began at the nipple, appears to be not Paget's disease but a lenticular scirrhus, apparently of primary cutaneous origin. If the

fleeting pain in the liver and the dropsy four months since were due to secondary invasion the abdomen might be expected at this stage to show more marked evidence of involvement. The main interest, however, lies in the distribution and spread of the carcinomatous process in definite nerve areas. In the earlier stages the eruption was so characteristic of nerve implication that it was actually mistaken for an intercostal herpes zoster by a medical man. The main part of the eruption began near the nipple in the segment supplied by the fifth dorsal nerve, and now occupies the segments supplied by the third to the sixth dorsal nerves. The right front of the chest is becoming invaded in a corresponding area. The comparatively recent site of invasion on the front of the shoulder-joint and over the biceps occur in areas supplied by cervical nerves. That on the inner side of the arm is apparently in the intercosto-humeral (third dorsal) region. It is not easy to imagine any growth of infection from the primary eruption to the secondary patches on arm along lymphatic routes.

The whole case is of much interest in connection with Mr. Lenthal Cheatle's observations on inflammatory changes in posterior spinal root ganglia in certain cases of cutaneous cancer. In the present instance the new growth presumably started in the cutaneous distribution of a single dorsal ganglion, but it now reaches the cutaneous distribution of neighbouring dorsal and cervical ganglia. The picture, viewed from behind, is specially suggestive of involvement of the posterior and lateral branches of dorsal, and, in the shoulder and arm, patches of cervical nerve.

Operation is clearly out of the question in a case of extensive *cancer en cuirasse* of this kind. On the recommendation of Dr. T. Shaw-Mackenzie preparations of pancreas and intestinal gland are being administered by the mouth, with excess of sugar in diet.

(2) A case of *fibromata of skin with developing neuro-fibroma.* The patient H. G—, male, aged 28 years, a Post Office worker, came June 18th, 1908, complaining of painless growths on front of chest and elsewhere of eight or nine years' duration. He says the growths appeared first at the time mentioned, and his mother is quite sure he had none as a child. Both the mother and one brother have similar growths on arms.

On examination, a group of small, firm, thickly set movable

subcutaneous nodules are to be seen on the right subclavian and sternal region. The surface involved measures about 3 inches by 7. The growths vary in size from a millet seed to a split-pea. They are painless and there is no tenderness on pressure except in the largest nodule, which is about the size of a marrow-fat pea. This nodule is extremely sensitive to pressure, a tenderness that is definitely due to nervous causes, and not to pressure irritation.

A small group of a dozen or more small nodules is below the right shoulder-blade, one of them being the size of a pea. A few others in an early stage are near the angle of the left scapula.

About the middle front of the left forearm is a linear transverse group of a dozen or so similar small nodules. In this place slight tenderness is felt on firm pressure upwards.

The distribution of the thoracic group is suggestive of a possible nerve origin. The one tender nodule further suggests the development of a nerve element in the growth. The probability seems to be that the nodules are simple fibromata, but it is hoped to settle the matter by a biopsy.

Many members considered this case an example of multiple leiomyomata cutis.

Dr. Whitfield showed a microscopical specimen and a pure culture of a yeast derived from a case of *intertriginous dermatitis of the cruro-scrotal region*. The patient was an elderly gentleman who had suffered from what appeared to be ordinary eczema intertrigo of the groins and perinæum. No marked marginate appearance was present and no other symptoms suggestive of parasitic origin. Examination of a scale showed, however, that the horny layer contained an abundance of large round bodies considerably larger than the spores of a trichophyton. Two scales from different parts of the eruption were planted out on Sabouraud's ringworm medium, and on both tubes a perfectly pure primary culture of yeast was obtained. The urine had been tested but no sugar had been found. Dr. Whitfield said that he considered that the yeast was in all probability causing the dermatitis, since it was found in such abundance and active growth in the scales.

CURRENT LITERATURE.

ON THE TRANSMISSION OF SYPHILIS TO THE THIRD GENERATION. Burgsdorf. (*Ann. de Derm. et de Syph.*, January, 1908, p. 18.)

Taking interstitial keratitis as the test of the presence of hereditary syphilis, Burgsdorf has made a minute examination of a case in which a little girl, aged 5 years, was the subject of interstitial keratitis, poor nutrition, loss of hair, and generally backward development. The father was found to be a congenital syphilitic with numerous symptoms of that condition. Acquired syphilis could be excluded in the mother and in the father and in the child herself, and other possible causes of interstitial keratitis could also be regarded as non-existent. Treatment on anti-specific lines resulted in rapid improvement of these conditions in the child. Cases, well authenticated, of the transmission of syphilis to the third generation, the possibility of which is widely disputed, are sufficiently rare to make this experience worth study.

E. G. L.

A CLINICAL STUDY OF KRAUROSIS VULVÆ. Thibierge. (*Ann. de Derm. et de Syph.*, January, 1908, p. 1.)

Thibierge begins his masterly study with the avowal that although he has examined the genitals of about 1000 women annually at the Broca Hospital he has overlooked this disease until quite recently. His attention having been drawn to it, he has satisfied himself that the condition is not uncommon, but the descriptions given of it lack clearness and accuracy, and consequently the diagnosis has been missed. He lays stress on the atrophic flattening and loss of hair of the labia majora, on the retraction and shininess of the skin on the nymphæ, on the diminution in the calibre of the vaginal orifice, on the smoothness of the whole vulval surface, on the variegation of colour, with frequent telangiectases and occasional pigmentation, but without the white spots or thickening of the epidermis described by Breisky and other authors after him.

In ninety-four women of all ages the condition was found in twelve, therefore kraurosis is far from being an uncommon disease. It is probably part of the senile change of the integuments in general, a change which may be hastened by castration.

Sixteen cases are cited in detail.

E. G. L.

NOTE ON THE COMPARATIVE INFLUENCE OF THE PARENTS IN HEREDITARY SYPHILIS. Carle. (*Ann. de Derm. et de Syph.*, February, 1908, p. 93.)

The greater certainty of contamination of the offspring with syphilis when the mother is infected than when the father alone is syphilitic has been energetically supported by numerous writers, and Carle adduces three well-narrated cases of healthy offspring resulting from the marriage of men suffering from syphilis in the early secondary period with women who remained uninfected, the children being born thirteen months, eighteen months, and nine months after the

appearance of the change in the father. In all three cases active treatment of the father had been undertaken, but no treatment of the mother. The children resulting from the union were observed up to an age of one and a half to two years and showed no signs of syphilis then.

E. G. L.

A CASE OF NODULAR LEPROSY CURED BY FINSEN-THERAPY. PASINI. (*Giorn. Ital. d. Mal. Ven. e della Pelle*, 1907.)

THE author reports a case of nodular leprosy occurring in a woman, a native of Uruguay. At the time (1906) when she presented herself for treatment she had already suffered from the disease for eight years. Clinically the diagnosis was unmistakable, for the appearance of the face was characteristic, the nodules were very numerous, and there was complete anæsthesia of the skin. Microscopical examination confirmed the clinical diagnosis. Nodules examined showed typical leprous structure. Treatment with Chaulmoogra oil and by the Röntgen rays were tried without success for some weeks. As a last resource it was determined to try the effect of the Finsen light. After three months' treatment, during which eighty-seven doses were given, great improvement was obtained, and the patient was shown at the meeting of the Congress of Dermatology. After a year's treatment all the nodules on the face, hands, and forearms had disappeared. The author was able to make a biopsy not only of a pure leprous nodule, but also of one in process of disappearing under treatment, and study the changes brought about by the action of the light. He concludes that the disappearance of the leprous nodules is caused by a process of degenerative vacuolisation of the specific elements which compose the leprous tissue; the action of the light conduces at the same time to the disintegration and to the reabsorption of the cellular elements, and to the destruction of the bacilli of Hansen.

H. D.

AN EPIDEMIC OF TINEA GRUBY-SABOURAUD IN THE PROVINCE OF COMO. PASINI. (*Atti. della Soc. Milanese di Medic. e Biologia*, vol. ii).

THE small-spored tinea which is found in about 80 to 90 per cent. of the cases of tinea in England is found in only 60 per cent. in Paris, and is rare in Belgium, Spain and Germany. In Italy, until recently, only four sporadic cases had been described, and one of these was not the common microsporon of London but that of the dog, and the other three were the microsporon of the horse. In 1906, however, the author found three cases of the common English microsporon in Como, and subsequently in an institution in Como where there live about 200 poor children he has found twenty-seven cases of this disease. He has also found three other children affected in the same way in other parts of the province. In every case he has found the *Microsporon Audouini*. The introduction of the disease is accounted for by the fact that large numbers of foreigners from France and England are continually passing through and staying at Como.

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